

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

OF PUBLIC HEALTH AND WELFARE

6254-60-045912  
6254 STATE FILE NUMBER

REGISTRATION DISTRICT NO. 149 Primary Registration District No. 1002 REGISTRAR'S NO. 6254

|                                                                                                       |  |                                                                                                                               |                                                                                                                                             |
|-------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY JACKSON                                                                |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE KANSAS b. COUNTY MONTGOMERY |                                                                                                                                             |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN KANSAS CITY                      |  | Length of stay in lb<br>20 days                                                                                               | c. CITY OR TOWN INDEPENDENCE                                                                                                                |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION VA HOSPITAL, K.C., MO. |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                          | d. STREET ADDRESS RT 4 (If outside, give location)<br>Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

|                                                                              |  |  |                                                      |  |
|------------------------------------------------------------------------------|--|--|------------------------------------------------------|--|
| 3. NAME OF DECEASED (Type or print)<br>First HOWARD Middle WILLIAM Last BELL |  |  | 4. DATE OF DEATH<br>Month DECEMBER 11, 1960 Day Year |  |
|------------------------------------------------------------------------------|--|--|------------------------------------------------------|--|

|             |                        |                                                                                                                                                             |                         |                           |                                |                              |
|-------------|------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|---------------------------|--------------------------------|------------------------------|
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 8-7-24 | 9. AGE (last birthday) 36 | IF UNDER 1 YEAR<br>Months Days | IF UNDER 24 HR<br>Hours Min. |
|-------------|------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|---------------------------|--------------------------------|------------------------------|

|                                                                                                                    |                                                          |                                                                 |                                       |
|--------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|-----------------------------------------------------------------|---------------------------------------|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>BODY AND FENDER MAN | 10b. KIND OF BUSINESS OR INDUSTRY<br>AUTOMOTIVE BUSINESS | 11. BIRTHPLACE (City and state or country)<br>EL DORADO, KANSAS | 12. CITIZEN OF WHAT COUNTRY<br>U.S.A. |
|--------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|-----------------------------------------------------------------|---------------------------------------|

|                                   |                                             |                                      |
|-----------------------------------|---------------------------------------------|--------------------------------------|
| 13a. FATHER'S NAME<br>THOMAS BELL | 13b. MOTHER'S MAIDEN NAME<br>ELIZABETH DUKE | 14. NAME OF HUSBAND OR WIFE<br>ANITA |
|-----------------------------------|---------------------------------------------|--------------------------------------|

|                                                                                                                       |                                        |                                                                                                    |
|-----------------------------------------------------------------------------------------------------------------------|----------------------------------------|----------------------------------------------------------------------------------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br>YES WW II | 16. SOCIAL SECURITY NO.<br>513-11-2918 | 17. INFORMANT<br>Anita Bell Wife Rt 4 Independence, Kansas<br>Official Records VA Hospital, K.C. M |
|-----------------------------------------------------------------------------------------------------------------------|----------------------------------------|----------------------------------------------------------------------------------------------------|

|                                                                                                          |                                           |                                  |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY: |                                           | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a)                                                                                      | Asphyxiation due to mucus plug in trachea |                                  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.               | DUE TO (b) Acute mucopurulent bronchitis  |                                  |
|                                                                                                          | DUE TO (c)                                |                                  |

|                                                                                                                                                      |                                                                                                                                                                      |
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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br>artery aneurysm | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
|------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|

|                                                                                                   |                                                                                                           |                                                                                                                                                                   |
|---------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)<br>Post operative state (crainotomy and clipping of middle cerebral/ |
|---------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|

|                                                           |  |
|-----------------------------------------------------------|--|
| 20c. TIME OF INJURY<br>Hour Month, Day, Year<br>a.m. p.m. |  |
|-----------------------------------------------------------|--|

|                                                                                                        |                                                                                          |                                           |
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| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION COUNTY STATE |
|--------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|-------------------------------------------|

21. attended the deceased from 12-6-60 to 12-11-60  
Death occurred at 9:00 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

|                                                      |                                           |                              |
|------------------------------------------------------|-------------------------------------------|------------------------------|
| 22a. SIGNATURE (Degree or title)<br>S. H. CHOY, M.D. | 22b. ADDRESS<br>VA Hospital, Kansas City, | 22c. DATE SIGNED<br>12-12-60 |
|------------------------------------------------------|-------------------------------------------|------------------------------|

|                                                      |                       |                                         |                                                                       |
|------------------------------------------------------|-----------------------|-----------------------------------------|-----------------------------------------------------------------------|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Removal | 23b. DATE<br>12-12-60 | 23c. NAME OF CEMETERY OR CREMATORY<br>- | 23d. LOCATION (City, town, or county) (State)<br>Independence, Kansas |
|------------------------------------------------------|-----------------------|-----------------------------------------|-----------------------------------------------------------------------|

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| 24. FEDERAL REGISTER ADDRESS<br>Newcomer's Sons<br>Kansas city, Missouri | 25. DATE RECD. BY LOCAL REG.<br>12-13-60 | 26. REGISTRAR'S SIGNATURE<br>H. L. Dwyer |
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed James W. Steg

Licensed Embalmer No. 3780  
P. O. Address Boonville

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to  
with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.